

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Page 4 may be retained by the hospital or attending physician. **MEDICAL CERTIFICATION** **UNUSUAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03733  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Medley's Neck</b>			c. LENGTH OF STAY IN 1b <b>30 years</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Medley's Neck</b>		
			d. STREET ADDRESS <b>1</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Victor</b> Middle <b>H.</b> Last <b>Brubacher</b>			4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>19 62</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 25, 1895</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Butterfield, Minnesota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Robert H. Brubacher</b>			14. MOTHER'S MAIDEN NAME <b>Johanna Hubin</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1918 - 1919</b>			16. SOCIAL SECURITY NO. <b>217-32-2285</b>		
17. INFORMANT <b>Sara Brubacher</b>			Address <b>Same as # 2 above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Paralysis</b> <b>356.1</b> DUE TO (b) <b>Angiotrophic Lateral Sclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>none</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>		
20c. TIME OF INJURY Month, Day, Year <b>none</b> 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>none</b>		20g. (County) <b>none</b>		20h. (State) <b>none</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/1/62</b> to <b>3/4/62</b> , that (I) (we) last saw the deceased alive on <b>3/1/62</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Julian S. Lane</b> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <b>Julian S. Lane M. D.</b>			22b. ADDRESS <b>Lexington Park, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 6, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>	
23d. LOCATION (City, town or county) <b>Leonardtown, Md.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>			ADDRESS <b>Leonardtown, Maryland</b>		
25a. REC'D BY REGISTRAR <b>W. C. 8 62</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		
DATE					

(M)

St. Louis

30 years

Virginia

Hotel Holiday's Neck

Hotel Holiday's Neck

Victor

H.

Armsman

White

Colonel

Living

born

Butterfield, Minnesota

Robert L. Treasurer

Johanna Hahn

1919 - 1920

1919 - 1920

*Handwritten notes:*  
Robert L. Treasurer  
Johanna Hahn  
1919 - 1920

*Handwritten signature:*  
Robert L. Treasurer

*Handwritten signature:*  
Johanna Hahn

John E. Anne M. D.

Lexington Park, Maryland

March 9, 1922

St. Paul, Minnesota

W. Oliver Hastings, Secretary, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove cause of death and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03737 03737

CERTIFICATE OF DEATH

03734

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Mechanicsville</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Almon</b> <b>Mason</b> <b>Clapp</b>		<b>4. DATE OF DEATH</b> <b>March 3, 1962</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 8, 1886</b>		<b>9. AGE</b> (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Training Officer V. A. Civil Service</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Washington, D. C.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>William Ellis Clapp</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ella Hedrick</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Mrs Ruth B. Clapp</b> <b>Mechanicsville, Maryland</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>159X</b> <b>Gastrointestinal red plasma with hemorrhage</b> DUE TO (b) <b>159X</b> <b>Pulmonary metastasis, Mrenia</b> DUE TO (c) <b>159X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 mo</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Mechanicsville, Maryland</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from June 3, 1961, to March 3, 1962, that (I) (we) last saw the deceased alive on March 3, 1962, and that death occurred at 11:00 A.M. from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <b>J. Roy Guyther M. D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>3/5/62</b>				<b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. Roy Guyther M. D.</b> <b>22d. ADDRESS</b> <b>Mechanicsville, Maryland</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>March 6, 1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>All Faith Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> <b>Charlotte Hall, Md.</b>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Clarke Mattingley</b>				<b>ADDRESS</b> <b>Leonardtwn, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>MAR 6 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>			



24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03738  
CERTIFICATE OF DEATH  
03735

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>F.</b> Last <b>Hebb</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hanson Hebb</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Ann Perpha</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 32 4451</b>	
17. INFORMANT <b>Joseph H. Hebb</b>		Address <b>1342 N. Fremount Ave Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure - Pneumonia</b> DUE TO <b>Hemiplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>3 52X</b> DUE TO <b>Hemiplegia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 15 1957</b> to <b>March 22, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 22, 1962</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles Greenwell</b>		22b. DATE <b>3/22/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b>		22d. ADDRESS <b>Leonardtwn Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/26/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Chapel</b>		23d. LOCATION (City, town or county) (State) <b>Medley's Neck, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
25a. REC'D BY REGISTRAR <b>W. Clarke Mattingley</b>		25b. REGISTRAR'S SIGNATURE <b>W. Clarke Mattingley</b>	

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03138

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

George F.

Hebb

March

22

22

Male

Colored

June 13, 1879

63

Laborer

Farmer

Maryland

U.S.A.

Hanson Hebb

William and George

215 32 4451 Joseph H. Hebb 1343 W. Fremont Ave

Baltimore, Md.

March 22, 63

March 22, 63

Charles Connolly W.D.

March 22, 63

Our Lady's Chapel

St. Mary's

W. Charles Connolly, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03739

03736

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural A bell</b> c. LENGTH OF STAY IN 1b <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Abell</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Julia Ann Hill</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>March 20, 1962</b>											
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 23, 1875</b>		<b>9. AGE</b> (In years last birthday) <b>86</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House wife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>James Henry Goode</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Turner</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <b>Mrs Helen Pingleton Abell, Maryland</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1957, to March 20, 1962, that (I) (we) last saw the deceased alive on March 19, 1962, and that death occurred at 2 A.M. from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <b>Charles Greenwell</b> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Charles Greenwell M. D.</b>				<b>22d. ADDRESS</b> <b>Leonardtown Md</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/22/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Sacred Heart Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) <b>Bushwood,</b>		<b>(State)</b> <b>Maryland</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Clarke Mattingley</b>				<b>ADDRESS</b> <b>Leonardtown, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>MAR 22 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanna</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03740

CERTIFICATE OF DEATH

03737

Items 8 & 9 Film G310 1/2/62 mh

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Elizabeth</b> Last <b>Latham</b>		4. DATE OF DEATH Month <b>March</b> Day <b>16,</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1877</b> <b>Feb. 13, 1877</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John R. Knott</b>		14. MOTHER'S MAIDEN NAME <b>Lottie Copsey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Ella R. Latham</b>		Address <b>Leonardtwn, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Embolic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 yrs.</b> <b>15 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>out</b> , 19 <b>57</b> , to <b>in</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David L. Mossman</b>		22b. DATE SIGNED <b>3/19/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>David L. Mossman M. D.</b>		22d. ADDRESS <b>Mechanicsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 19, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Chapel</b>		23d. LOCATION (City, town or county) (State) <b>Medley's Neck, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>MAR 22 '62</b>	
ADDRESS <b>Leonardtwn, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

03707

(M)

03707

RECORDS OF DEATH

NAME	AGE	SEX	DATE OF DEATH	PLACE OF DEATH	Cause of Death
John E. Knox	70	M	Nov. 13, 1918	Home	Heart Disease
James E. White	65	M	Nov. 13, 1918	Home	Heart Disease
William E. White	65	M	Nov. 13, 1918	Home	Heart Disease
William E. White	65	M	Nov. 13, 1918	Home	Heart Disease

NAME	AGE	SEX	DATE OF DEATH	PLACE OF DEATH	Cause of Death
David E. Johnson	70	M	Nov. 13, 1918	Home	Heart Disease
William E. White	65	M	Nov. 13, 1918	Home	Heart Disease
William E. White	65	M	Nov. 13, 1918	Home	Heart Disease
William E. White	65	M	Nov. 13, 1918	Home	Heart Disease

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03741

## CERTIFICATE OF DEATH

Reg. Dist. No. 03738

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Mary's</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN 1b <u>5 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>75 East Rennell Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Nancy</u> Middle <u>Lee Anne</u> Last <u>Lester</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>2</u> Year <u>62</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-62</u>		9. AGE (In years last birthday) <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Merrill Lester</u>				14. MOTHER'S MAIDEN NAME <u>Janet Lee Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mother</u>		Address <u>same</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prerenatality</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/2</u> 19 <u>62</u> to <u>3/2</u> 19 <u>62</u> , that I last saw the deceased alive on <u>3/2</u> 19 <u>62</u> , and that death occurred at <u>9:35</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Great Mills, Md.</u> DATE SIGNED <u>5/3/62</u>							
ACTUAL SIGNATURE <u>James P. Jarboe</u>		M.D.					
PHYSICIAN'S NAME (Type) <u>Dr. James P. Jarboe</u>		Great Mills, Md.					
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		22d. LOCATION (City, town, or county) (State) <u>Leonardtown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingly</u>				ADDRESS <u>Leonardtown, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifford S. Hanna</u>			

CERTIFICATE OF DEATH

03741

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES EARL RAY		MALE		35		12-1-27		MEMPHIS, TENN.		PACIFIC AIRLINES	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
4-4-68		10:00 AM		MEMPHIS, TENN.		HEART DISEASE		SUICIDE		JAMES EARL RAY	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER		21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE		23. SIGNATURE OF CLERK		24. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

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## CERTIFICATE OF DEATH

Reg. Dist. No. 03740

1. PLACE OF DEATH o. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>39 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norris</u>				4. DATE OF DEATH Month Day Year <u>3-2-62</u> <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-62</u>	9. AGE (In years lost birthday) <u>—</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	<u>39</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Joseph Aloysius Norris</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Ann Blackiston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/2</u> , 19 <u>62</u> to <u>3/3</u> , 19 <u>62</u> that I last saw the deceased alive on <u>3/2</u> , 19 <u>62</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. James P. Jarboe</u>				DATE SIGNED <u>3/3/62</u>			
PHYSICIAN'S NAME (Type) <u>Dr. James P. Jarboe</u>				ADDRESS <u>Great Mills, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St John's</u>		22d. LOCATION (City, town, or county) (State) <u>Hollywood Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McLorke Mattingly Leonardtown, Md</u>				24a. REC'D BY REGISTRAR DATE <u>3/5/62</u>		24b. REGISTRAR'S SIGNATURE <u>Richard L. Hester</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

252

22/2/20

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 5, should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03744 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03741											
Item 2 Film G309 3/16/62 iwk											
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland Ohio</b> b. COUNTY <b>St. Mary's</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>				c. LENGTH OF STAY IN lb <b>2 1/2 months</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Patuxent River/ Greenville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Station Hospital, USNAS</b>				d. STREET ADDRESS <b>U.S. Naval Air Station</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Thomas Michael OAKLEY</b>				4. DATE OF DEATH <b>March 7 19 62</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT 19 1943</b>		9. AGE (In years last birthday) <b>18</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>GREENVILLE, OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Marvin C. OAKLEY</b>				14. MOTHER'S MAIDEN NAME <b>Martha SCHOOLER</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 15 Sep 61 to 7 MAR 62</b>				16. SOCIAL SECURITY NO. <b>271 387 716</b>				17. INFORMANT <b>OFFICIAL NAVAL RECORDS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage secondary to Laceration Liver</b> <b>936.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <b>98 Minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <b>Crushed between two hangar doors at Hangar 109</b>							
20c. TIME OF INJURY Month, Day, Year <b>1:42 p.m. MARCH 7 1962</b>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hangar 109, USNAS, Patuxent River, Maryland</b>		20f. (City or town) (State) <b>St. Mary's</b> (County)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>G. R. SWAN</b> EXAMINER'S NAME (Type) <b>USNAS, Station Hospital, Patuxent River, Md.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>William D. BOYD</b> DATE SIGNED <b>March 1962</b> <b>Leonardtwn, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit Burial 3/9/62</b>				22b. DATE THEREOF <b>3/9/62</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Greenville, Ohio</b>			
23. FUNERAL DIRECTOR <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 12 '62</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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*[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03745

CERTIFICATE OF DEATH

03742

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chaptico</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chaptico</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Life</b>			d. STREET ADDRESS <b>Chaptico</b>		
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Garner</b> Last <b>Reeves</b>			4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1962</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1881</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Chaptico, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>George R. Garner</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Thomas</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mr S. Sprigg Reeves Jr. Leonardtown, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure - aortic stenosis</b> <b>422.1</b> DUE TO <b>ASCD's.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>March 10, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 1, 1962</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>J. Roy Guyther M. D.</b>					
22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type). <b>J. Roy Guyther M. D.</b>					
22d. ADDRESS <b>Mechanicsville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 12, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>	
23d. LOCATION (City, town or county) <b>Chaptico, Maryland</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 19 '62</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03746

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03743

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Compton</b> c. LENGTH OF STAY IN 1b <b>30 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Compton</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>I.</b> Last <b>Stewart</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 1891</b>		9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hollywood, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? ?</b>				14. MOTHER'S MAIDEN NAME <b>? ?</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Annie Stewart</b> Address <b>1353 E. St S.E. Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				Caronary Infarct				INTERVAL BETWEEN DEATH AND DEATH <b>Immed.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				DATE SIGNED <b>3/31/62</b>	
ACTUAL SIGNATURE <b>William D. Boyd</b> EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/5/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Va.</b>			
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 9 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

MEDICAL CERTIFICATION

(M)

Compton

30 yrs.

Amal

Compton

St. Mary's

Maryland

St. Mary's

Male Colored

May

1901

70

farm laborer

Hollywood, Maryland

Coronary infarct

Funeral 4/1/02

Interment National

Cemetery

W. J. ...

William D. Ford

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03744

03744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN 1b <b>10 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Reindert</b> Middle <b>Tuinman</b> Last <b>Tuinman</b>			<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>14</b> Year <b>1962</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Oct. 27, 1890</b>		<b>9. AGE</b> (In years last birthday) <b>71</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>7</b> Days <b>14</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Amsterdam, Holland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			<b>13. FATHER'S NAME</b> <b>Reindert Tuinman</b>				
<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Lung</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW1</b>				
<b>16. SOCIAL SECURITY NO.</b> <b>216-16-0078</b>			<b>17. INFORMANT</b> <b>Agnes G. Tuinman</b> Address <b>Leonardtwn, Maryland</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>3/14</b> , 19 <b>62</b> , to <b>3/14</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> , 19 <b>62</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>William D. Boyd</i> M.D.			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>3/16/62</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>William D. Boyd M. D.</b>			<b>22d. ADDRESS</b> <b>Leonardtwn, Maryland</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>March 17, 1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Aloysius</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Leonardtwn,</b>		<b>23e. (State)</b> <b>Md.</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Clarke Mattingley</b>			<b>ADDRESS</b> <b>Leonardtwn, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 19 '62</b>		
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. House</i>							

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Charles Hittinger, Secretary, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, place in envelope and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03748

03745

1. PLACE OF DEATH o. COUNTY <b>St. Marys</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		d. STREET ADDRESS <b>Rural</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>INFANT BOY GARY WAGGONER</b>		4. DATE OF DEATH Month Day Year <b>March 21 <del>20</del> 1962</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 20, 1962</b>	
9. AGE (In years lost birthday) yrs. <b>7</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Thomas J. Waggoner</b>		14. MOTHER'S MAIDEN NAME <b>Mary V. Roach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Thomas J. Waggoner - Ridge, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prob. intra cranial hemorrhage</b> <b>7605</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Premature birth - breech presentation</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/20/62</b> 19 to <b>3/21/62</b> 19, that (I) (we) last saw the deceased alive on <b>3/20</b> 19, and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Roy Guyther</b>		22b. DATE SIGNED <b>3/21/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Roy Guyther, MD</b>		22d. ADDRESS <b>Mechabicsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/22/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Ridge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 27 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>			

2-055322

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(M)

STATE OF DEATH

DECEASED

DATE

PLACE

CAUSE

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

SEX

PLACE

CAUSE

NAME

NAME

NAME



DATE

NAME

NAME

NAME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY in 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Hughesville</b> d. STREET ADDRESS <b>Box 144</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Joseph E. Woodland</b>		<b>4. DATE OF DEATH</b> <b>March 11, 1962</b>		<b>5. SEX</b> <b>Male</b>			
<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 3, 1910</b>			
<b>9. AGE</b> (In years last birthday) <b>51 yrs.</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Civil Service</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>William Woodland</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Dorsey</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>202-628-2709</b>			
<b>17. INFORMANT</b> <b>Alice M. Woodland, Box 144, Hughesville, Md.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>Coronary Thrombosis</b> <b>420.1</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b> (b) <b>DUE TO</b> (c) <b>DUE TO</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Hypertensive CV disease</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Mar 9, 1962</b>			
<b>20f. (City or town)</b> <b>Mar 11, 1962</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Mar 9, 1962</b> <b>to</b> <b>Mar 11, 1962</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Mar 11, 1962</b> , <b>and that death occurred at</b> <b>8:18 A.M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>J. Roy Gwyther</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. Roy Gwyther</b>		<b>22b. DATE SIGNED</b> <b>Mar 11, 1962</b>			
<b>22d. ADDRESS</b> <b>Mechanicsville, Maryland</b>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3-14-62</b>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St Marys</b>		<b>23d. LOCATION</b> (City, town or county) <b>Bryantown, Maryland</b>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The Hunt Funeral Home, Waldorf, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 15 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

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VR A15 (4)  
15M 7/61

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5M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03750					03747									
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Hollywood</b> d. STREET ADDRESS <b>Box 140</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Louise V Zafiros</b> First Middle Last 4. DATE OF DEATH <b>March 14, 1962</b> Month Day Year					5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept. 8, 1908</b> 9. AGE (In years last birthday) <b>53</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>				
13. FATHER'S NAME <b>Charles Alexandra</b>					14. MOTHER'S MAIDEN NAME <b>Nora ?</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>					16. SOCIAL SECURITY NO. <b>577-05-0532</b>					17. INFORMANT <b>Alexandrea J. Zafiros</b> Address <b>Hollywood, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>434.3</b> DUE TO <b>Pericarditis</b> Conditions, if any, which gave rise to immediate cause (b) <b> viral pneumonia</b> (c) <b>chronic alcoholism</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic alcoholism</b>										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>3-8-62</b> to <b>3-14-62</b> that (I) (we) last saw the deceased alive on <b>3-4-62</b> and that death occurred at <b>8:15 AM</b> from the causes and on the date stated above										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22a. SIGNATURE <b>Michael Barbarich</b> M.D.					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <b>Michael Barbarich M. D.</b>					22d. ADDRESS <b>329 Great Mills Rd. Lexington Park, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>March 17, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>1801 E. Street S.E. Wash. D.C.</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Maryland</b>					25a. REC'D BY REGISTRAR <b>W. Clarke Mattingley</b> DATE <b>MAR 19 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>							

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